



**AUTHORIZATION TO RELEASE DENTAL RECORDS TO
TIOGA DENTAL & ORTHODONTICS**

TO: OFFICE NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _____

I authorize the release of my dental records: clinical notes, patient forms (including medical history), photos and x-rays relevant to dental treatment and request that they be transferred as soon as possible to:

**Tioga Dental & Orthodontics
13005 SW 1st Rd, Ste. 233
Jonesville, FL 32669
352-333-1946
info@tiogadental.com**

PLEASE NOTE RECORDS TYPICALLY TAKE 5 TO 7 DAYS TO PROCESS

Name of Patient

Parent/Guardian (if applicable)

Signature of Patient or Parent/Guardian

Date

352 333-1946 www.TiogaDental.com

13005 SW 1st Road, Ste 233 • Gainesville, FL 32669

INFO@TIOGADENTAL.COM